STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 01 B. WING	10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/26/12 Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Harcourt Terrace Nursing and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type III (211) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 116 and had a census of 91 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/31/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 1. Based on observation and interview, the facility failed to ensure 1 of 1 kitchen doors to the Main Dining Room was provided with a positive latching device to latch the door into the door frame. This deficient practice could affect 45 residents, staff and visitors in the vicinity of the Main Dining Room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 10:55 a.m. to 1:35 p.m. on 10/26/12, the kitchen door to the Main Dining Room was not equipped with a positive latching device to latch the door into the frame. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the kitchen door to the Main Dining Room was not equipped with a positive latching device	K0029	The creation and submission of this Plan of Correction does not constitue an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567L, Plan of Correction, be considered the Letter of Credible Allegation of Compliance and respectfully requests a desk review of the enclosed information. K0029 It is the practice of this provider to ensure that all hazardous areas are protected by a one hour fire rated construction or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?No residents were affected.2. How will you identify other residents	11/20/2012

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	to latch the door into the frame. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 kitchen dishwashing rooms was separated from the Main Dining Room with smoke resisting doors. This deficient practice could affect 45 residents, staff and visitors in the vicinity of the Main Dining Room. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 10:55 a.m. to 1:35 p.m. on 10/26/12, the kitchen dishwashing room was open to the kitchen. In addition, the kitchen dishwashing room is open to the Main Dining Room because dishes used in the Main Dining Room are passed through a service window which was open to the Main Dining Room. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the kitchen dishwashing room was open to the kitchen and the kitchen dishwashing room is also open to the Main Dining Room. 3.1-19(b)		having the potential to be affected by these deficient practices and what corrective action will be taken?All residents that eat in the main dining area have the potential to be affected. A new maintenance director will be educated by corporate maintenance personnel on this code when hired. All staff will be inserviced on the new door system by 11-20-12.3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?A 48 inch, 1 hour fire rated door will be installed to seperate the main dining room from the kitchen/dishroom by 11-15-12. The doors will be attached to the facility fire alarm system with magnetic holds so that when the fire alarm sounds the doors will release providing protection to the hazardous area. The doors will also have a panic bar installed and be self closing into a positive latching frame.A new maintenance director will be educated by corporate maintenace personnel on this code when hired. All staff will be inserviced on the new door system by 11-20-12. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place?A cqi tool to monitor hazardous areas will be completed weekly x4, monthly x2	

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			and quarterly thereafter, for at least 6 months. Action plans will be adjusted until 95% compliance is achieved.5. Date of compliance 11-20-12	

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K0048 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in the written fire safety plan for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect 45 residents, staff and visitors in the vicinity of the Main Dining Room. Findings include: Based on review of the facility's written fire disaster plan labeled "Fire Prevention" and "Fire Plan" with the Maintenance Supervisor during record review from 9:35 a.m. to 10:55 a.m. on 10/26/12, the fire disaster plans did not address the use of the ABC type fire	K0048	K0048 It is the practice of this provider to ensure there is a written plan for the protection of all patients and for their evacuation in the event of an emergency.1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?No residents were affected.2. How will you identify other residents having the potential to be affected by these deficient practices and what corrective action will be taken?All residents that reside at the facility have the potential to be affected. A new maintenance director will be educated on this code by corporate maintenance personnel when hired. All staff will be inserviced on the disaster plan edit to include the use of kitchen fire extinguishers 11-20-12.3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? The facility disaster plan was updated to include the use of kitchen fire extinguishers on 11-10-12A new maintenance director will be educated on this code by corporate maintenance personnel when hired. All staff will be inserviced on the edit to the disaster plan to include the	11/20/2012

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	extinguishers and the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview at the time of record review, the Maintenance Supervisor acknowledged the written fire safety plans for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K-class fire extinguisher. 3.1-19(b)		use of kitchen fire extinguishers 11-20-12. 4. How will the corrective action(s) be monitored to ensure teh deficient practice will not recur, ie, what quality assurance program will be put into place?A cqi tool will be completed monthly to review the disaster plan x3, and quarterly thereafter, for at least 6 months. Action plans will be adjusted until 95% compliance is achieved.5. Date of compliance 11-20-12	

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K0064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 1. Based on observation and interview, the facility failed to ensure 3 of 13 portable fire extinguishers requiring a 12 year hydrostatic test were emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. Fire extinguishers passing the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 inches by 3 1/2 inches. The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self destructive type when removal from a fire extinguisher is attempted. The label shall include the following information: (a) Month and year the maintenance was performed, indicated by a perforation such as is done by a hand punch. (b) Name or initials of person performing the maintenance and name of agency performing the maintenance. NFPA 10 at Section 4-4.4.2, Verification of Service (Maintenance or Recharging) requires each extinguisher that has	K0064	K0064 It is the practice of this provider to ensure there are portable fire extinguishers in all health care occupancies in accordance with 9.7.4.1.1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?No residents were affected.2. How will you identify other residents having the potential to be affected by these deficient practices and what corrective action will be taken?All residents that reside at the facility have the potential to be affected. A new maintenance director will be educated on the monitoring of fire extinguisher collars by corporate maintenance personnel when hired. The housekeeping and laundry supervisor will be inserviced as a back up designee3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?The facility outside vendor corrected the 3 portable fire extinguishers on 10-30-12.A new maintenance director will be educated on this code when hired by corporate maintenance personnel. The housekeeping and laundry supervisor will be inserviced as a back up designee4. How will the	11/20/2012

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	undergone maintenance that includes internal examination or has been recharged shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. This deficient practice could affect 14 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 10:55 a.m. to 1:35 p.m. on 10/26/12, the following was noted for three portable fire extinguishers in the facility: a. the portable fire extinguisher by the Cedar Bay nurses' station had a label affixed stating the six year maintenance procedures were performed in March 2011 but it had no verification of service collar located around the neck of the container.		corrective action(s) be monitored to ensure teh deficient practice will not recur, ie, what quality assurance program will be put into place?A cqi tool that will monitor the fire extinguisher collars will be completed monthly x3, and quarterly thereafter, for at least 6 months. Action plans will be adjusted until 95% compliance is achieved.5. Date of compliance 11-20-12	

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	b. the portable fire extinguisher located in the basement by the Maintenance Office was manufactured in 1989 and had a label affixed stating the most recent six year maintenance procedures were performed in April 2007 but it had no verification of service collar located around the neck of the container. c. the portable fire extinguisher located in the basement corridor was manufactured in 2005 and had a label affixed stating the six year maintenance procedures were performed in April 2011 but it had no verification of service collar located around the neck of the container. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged each of the three portable fire extinguishers in the facility was not provided with a verification of service collar in the aforementioned locations. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain 1 of 1 portable K-class fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils			

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	and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect staff or visitors in the vicinity of the kitchen. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 10:55 a.m. to 1:35 p.m. on 10/26/12, a placard was not conspicuously placed near the K-class portable fire extinguisher which states the fire protection system shall be activated prior to using the K-class portable fire extinguisher. Based on interview at the time of observation, the Maintenance Supervisor acknowledged a placard was not conspicuously placed near the K-class portable fire extinguisher stating the fire protection system shall be activated prior to using the K-class portable fire extinguisher.			

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	3.1-19(b)			

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K0076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage locations of greater than 3000 cubic feet was enclosed with a separation of 1 hour fire resistive construction. This deficient practice could affect 30 residents and any staff or visitor in the vicinity of the oxygen storage and transfilling room near the Willow Bend nurses' station. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 10:55 a.m. to 1:35 p.m. on 10/26/12, the following was noted for the oxygen storage and transfilling room near the Willow Bend nurses' station: a. the entry door had no fire resistance rating label attached to the door. Seven liquid oxygen tanks were observed in the room. b. an "L" shaped cut measuring 24 inches	K0076	K0076 It is the practice of this provider to ensure that medical gas storage areas are protected in accoradance with NFPA 99 standards for health facilities.1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?No residents were affected.2. How will you identify other residents having the potential to be affected by these deficient practices and what corrective action will be taken?All residents that reside at the facility have the potential to be affected. A new maintenance director will be educated on this code when hired by corporate maintenance personnel. All staff will be inserviced on appropriate oxygen storage on 11-20-12.3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? The facility repaired the hole in the wall of the oxygen storage	11/20/2012

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	long was observed in the wall near the floor by the entry room door which was not firestopped. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the entry door for the oxygen storage and transfilling room near the Willow Bend nurses' station was not one hour fire rated and the "L" shaped cut in the wall did not provide one hour fire resistive construction. 3.1-19(b)		room on 11-8-12. A new 1 hour fire rated door was installed for the oxygen storage room on 11-8-12.A new maintenance director will be educated on this code when hired by corporate maintenance personnel. All staff will be inserviced on appropriate oxygen storage on 11-20-12.4. How will the corrective action(s) be monitored to ensure teh deficient practice will not recur, ie, what quality assurance program will be put into place?A cqi tool that will monitor the integrity of oxygen storage will be completed weekly x 4, monthly x2, and quarterly thereafter, for at least 6 months. Staff monitoring will report non-compliance immediately to the Executive Director/Designee. Action plans will be adjusted until 95% compliance is achieved.5. Date of compliance 11-20-12	

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HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

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K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 2 liquid oxygen storage areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 30 residents and any staff or visitor in the vicinity of the oxygen storage and transfilling room near the Willow Bend nurses' station. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 10:55 a.m. to 1:35 p.m. on 10/26/12, the following was noted for	K0143	K0143 It is the practice of this provider to ensure that the transferring of oxygen is seperated from any portion of a facility wherein patients are housed, examined or treated by a separation or a fire barrier of 1 hour fire resistive construction.1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?No residents were affected.2. How will you identify other residents having the potential to be affected by these deficient practices and what corrective action will be taken?All residents that reside at the facility have the potential to be affected. A new maintenance director will be educated on this code when hired by corporate maintenance personnel. All staff	11/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 01 B. WING	10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

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	the oxygen storage and transfilling room near the Willow Bend nurses' station: a. the entry door had no fire resistance rating label attached to the door. Seven liquid oxygen tanks were observed in the room. b. an "L" shaped cut measuring 24 inches long was observed in the wall near the floor by the entry room door which was not firestopped. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the entry door for the oxygen storage and transfilling room near the Willow Bend nurses' station was not one hour fire rated and the "L" shaped cut in the wall did not provide one hour fire resistive construction. 3.1-19(b)		will be inserviced on appropriate oxygen storage on 11-20-12.3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? The facility repaired the hole in the wall of the oxygen storage room on 11-8-12. A new 1 hour fire rated door was installed for the oxygen storage room on 11-8-12.A new maintenance director will be educated on this code when hired by corporate maintenance personnel. All staff will be inserviced on appropriate oxygen storage on 11-20-12.4. How will the corrective action(s) be monitored to ensure teh deficient practice will not recur, ie, what quality assurance program will be put into place?A cqi tool that will monitor the integrity of oxygen storage will be completed weekly x 4, monthly x2, and quarterly thereafter, for at least 6 months. Staff will report any compromise of integrity in the oxygen storage room to the Executive Director immediately. Action plans will be adjusted until 95% compliance is achieved.5. Date of compliance 11-20-12	